Dental and Dental Plus

Dental and Dental Plus Table of Contents

Introduction

Keeping your teeth in good shape is important to your health. That is why we offer the State Dental Plan and Dental Plus, a supplemental dental program. To participate in Dental Plus, you must be enrolled in the State Dental Plan, and you must carry the same level of coverage—cover the same family members—under both plans.

The State Dental Plan offers these levels of treatment: diagnostic and preventive, basic, prosthodontics, and orthodontia. They are described on page 66. The benefit for orthodontia, the correction of irregular teeth, which often involves braces, is limited.

Dental Plus covers the first three levels of service at the same percentage of coverage as the State Dental Plan. However, the allowance is higher. **Dental Plus does not cover orthodontia.**

Under Dental Plus, reimbursement is based on what your dentist charges, up to the maximum Dental Plus allowance. That allowance is based on what most dentists in South Carolina charge for particular services.

This means that your dental expenses may fall within these allowances, and you may only be responsible for paying the deductible and coinsurance. If your dentist charges more for covered services than Dental Plus allows, **you will be responsible for paying the difference** unless your dentist has agreed to accept the Dental Plus allowance.

The Employee Insurance Program (EIP) offered agreements to all South Carolina dentists to accept the lesser of their usual charges or the Dental Plus maximum allowances. To find the list of dentists that have accepted the agreement go to the EIP Web site, www.eip.sc.gov, select "Links," and then "State Dental Plan/Dental Plus." If your dentist does not participate, your level of benefits under Dental Plus will not be reduced. However, you may have higher out-of-pocket expenses.

The **combined** maximum yearly benefit for both the State Dental Plan and Dental Plus is $1,500 per covered person. The yearly maximum for the State Dental Plan alone is $1,000 per covered person.

There are no additional deductibles and coinsurance under Dental Plus. However, there *is* a deductible under the State Dental Plan. That amount is $25 per covered person annually for dental services under Class II and Class III. The maximum deductible for family coverage is for three persons, or $75.

Your State Dental Plans at a Glance

Not all dental procedures are covered. Please see pages 68-70 for more information.

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	**State Dental Plan**	None	100% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	None	Up to 100% of allowance or actual charge (whichever is less)	$1,500[2] per person each benefit year combined for Classes I, II and III
II Basic Benefits	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures	**State Dental Plan**	$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	80% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	Up to 80% of allowance after State Dental Plan deductible is met	$1,500[2] per person each benefit year combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	**State Dental Plan**	$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	50% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	Up to 50% of allowance after State Dental Plan deductible is met	$1,500[2] per person each benefit year combined for Classes I, II and III
IV Orthodontia[1]	Limited to covered children under age 19 Correction of malocclusion Consisting of: diagnosis (including models and X-rays) Active treatment (including necessary appliances)	**State Dental Plan**	None	50% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	**Dental Plus does not offer orthodontia benefits.**	**Dental Plus does not offer orthodontia benefits.**	**Dental Plus does not offer orthodontia benefits.**

[1] A subscriber must provide a letter from his provider stating that orthodontia is not for cosmetic purposes for it to be covered by the State Dental Plan.

[2] $1,500 is the total yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

CLAIM EXAMPLES (USING CLASS III PROCEDURE CLAIMS)

Under the State Dental Plan and Dental Plus, Class III dental benefits, prosthetics, are paid at 50 percent of the allowance. How the two plans work together, based on a crown (resin with predominant base metal), is illustrated below.

When Dentist's Charge Does Not Exceed Dental Plus Allowance

Dentist's charge for Class III procedure $680.00
State Dental Plan (SDP) benefit .....$174.50 (50% of $349[1])
Dental Plus (DP) benefit .....$343.00 (50% of $686[2])

Maximum reimbursable amount (50% of dentist's charge or DP allowance, whichever is less).....$340.00
SDP benefit .....- $174.50
Remaining reimbursable amount $165.50
Dental Plus benefit .....-$165.50

Dentist's charge $680.00
Total benefits paid .....-$340.00
Patient owes .....$340.00[3]

When Dentist's Charge Exceeds Dental Plus Allowance

Dentist's charge for Class III procedure $800.00
State Dental Plan (SDP) benefit .....$174.50 (50% of $349[1])
Dental Plus (DP) benefit .....$343.00 (50% of $686[2])

Maximum reimbursable amount (50% of dentist's charge or DP allowance, whichever is less).....$343.00
SDP benefit .....-$174.50
Remaining reimbursable amount $168.50
Dental Plus benefit .....-$168.50

Dentist's charge $800.00
Total benefits paid .....-$343.00
Patient owes .....$457.00[4]
Patient owes if dentist is in network.....$343.00[5]

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[1]$349 is the allowance for this procedure under the State Dental Plan.
[2]$686 is the allowance for this procedure under Dental Plus.
[3]Without Dental Plus, the patient would owe $505.50 in this example.
[4]Without Dental Plus, the patient would owe $625.50 in this example.
[5]Participating dentists have agreed to accept the Dental Plus allowance.

HOW TO FILE A DENTAL CLAIM

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, you must show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file claims for you, you can file with BlueCross BlueShield of South Carolina. See page 184 for information on how to file a dental claim.

If you are covered under Dental Plus, BlueCross BlueShield will process your dental claims under the State Dental Plan and then under Dental Plus. You do not have to submit any additional claims.

SPECIAL PROVISIONS OF THE STATE DENTAL PLAN

Alternate Forms of Treatment

If you or your dentist selects a more expensive or personalized treatment, benefits will be paid for the less costly procedure consistent with sound professional standards of dental care. The claims processor uses guidelines based on usual and customarily provided services and standards of care to determine benefits and/or denials.

Voluntary Pre-authorization

Although it is not required, EIP suggests that you pre-authorize your non-emergency treatment if you have estimated charges of $500 or more. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina (BCBSSC) for review.

You and your dentist will receive a Predetermination of Benefits form, which will show what part of the expenses your dental plan will cover. This form can be used to file for benefits as the work is completed. Just fill in the date(s) of service, sign the form, have your dentist sign the form and return it to BCBSSC. Your pre-authorization is valid for one year from the date of the form. However, the date of service may affect your benefits. For example, if you have reached your maximum benefit by the time you have the pre-authorized service, you will not receive the amount that was approved on the Predetermination of Benefits form.

Emergency treatment does not have to be pre-authorized.

DENTAL SERVICES NOT COVERED

There are some dental services the State Dental Plan and Dental Plus do not cover. The dental plan document, which is available in your benefits administrator's office, lists all these exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General Services

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered if performed under the supervision and direction of a dentist
- Services beyond the scope of the dentist's license
- Services performed by a dentist who is a member of a covered person's family and for which the covered person was not previously charged and did not pay the dentist
- Dental services or supplies that are rendered before the date you are eligible for coverage under this plan
- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss)
- Non-dental services, such as broken appointments and completion of claim forms
- Nutritional counseling for the control of dental disease, oral hygiene instruction and training in preventive dental care
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit
- Services or supplies not recommended and approved by the attending dentist
- Services or supplies not recognized as acceptable dental practices by the American Dental Association

Services Covered by Another Plan

- Treatment for which the covered person is entitled under any Workers' Compensation law
- Services or supplies that are covered by the armed services of a government
- Services or supplies that are furnished in a U.S. government facility (or its agent) or by a doctor employed by such a facility

Specific Procedures

- Space maintainers for lost deciduous teeth if the dependent is age 19 or older
- Experimental services or supplies
- Onlays and crowns, when used for preventive purposes or due to erosion, abrasion, or attrition
- Services and supplies for cosmetic or esthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as provided for under this plan
- Myofunctional therapy (i.e., correction of tongue thrusting)
- Appliances or therapy for the correction of temporo mandibular joint syndrome (TMJ)
- Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition
- Splinting or periodontal splinting, including extra abutments for bridges
- Services for the following tests and laboratory examinations: bacterial cultures for determining pathological agents, caries (tooth or bone destruction), susceptibility tests, diagnostic photographs and histopathologic exams
- Pulp cap, direct and indirect (excluding final restoration)
- Provisional intracoronal and extracoronal (crown) splinting
- Tooth transplantation and surgical repositioning of teeth
- Occlusal adjustment (complete)
- Services for temporary repair of fractured teeth
- Rebase procedures
- Implant and related services (including prosthodontics (crowns and abutments) placed on implants)
- Stress breakers
- Precision attachments
- Temporary procedures that are considered part of a more definitive treatment
- Inlays (cast metal and/or composite, resin, porcelain, ceramic) are not considered a benefit. Benefits for inlays are based on the allowance of an alternate amalgam restoration.

Limited Services

- More than two of the following procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis
- More than two periodontal prophylaxes (available only to patients who have a history of periodontal surgery). An additional two periodontal prophylaxis may be performed in lieu of two prophylaxis procedures provided above.
- Bitewing X-rays more than twice during any benefit year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist
- More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year
- Topical application of sealants per tooth for unrestored, recently erupted molars for patients age 16 and older. For patients age 15 and under, payment is limited to one treatment every three years and applies to permanent unrestored molars only.
- More than one root canal treatment on the same tooth. Additional treatment should be submitted with the appropriate American Dental Association procedure code and documentation.
- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing
- Bone replacement grafts performed on the same site more than once in any 36-month period
- Additional sites in excess of two bone replacement grafts performed on the same day. (Payment is limited.)
- Periodontal scaling for treatment of gingival inflammation if performed more than once per lifetime
- Tissue conditioning for upper and lower dentures if performed more than twice per unit in any 36-month period
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations is not considered a separate benefit
- There is a five-year replacement limitation for cast restoration and prosthodontics.
- The application of desensitizing medicaments is limited to two times per quadrant per year.
- No more than one composite or amalgam restoration per surface in a 12-month period
- Replacement of an existing cast prosthodontic, including crowns, partial or full removable denture or fixed bridgework, or addition of teeth to an existing partial, removable denture or bridgework, unless evidence

is submitted and is satisfactory to the administrator that: (1) the addition of teeth is required for the initial replacement of one or more natural teeth; (2) the existing denture or bridgework was installed at least five years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or (3) the existing denture is an immediate temporary denture, and replacement by a permanent denture is required, and that such replacement is delivered or installed within a period of 12 consecutive months following the date of installation of the immediate temporary denture.

Prosthodontic and Orthodontic Services

- Prosthodontic devices (including bridges and crowns) and their fitting that were ordered while the person was covered under the plan, but were installed or delivered more than 90 days after termination of coverage
- Replacement of lost or stolen prosthodontic devices, space maintainers or orthodontic appliances or charges for spare or duplicate dentures and appliances
- Replacement of broken orthodontic appliances
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document
- Orthodontic treatment for employees and covered children ages 19 and older
- Orthodontic treatment over the lifetime maximum
- Orthodontic services after the month your dependent becomes ineligible for coverage

Please note: Dental Plus does not cover orthodontic services.

STATE DENTAL PLAN AND DENTAL PLUS APPEALS

If BlueCross BlueShield of South Carolina (BCBSSC) denies all or part of your claim or of your proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this book or call for an explanation. If you are unsure the decision was fair, you can ask BCBSSC to re-examine the denial of your claim or of your proposed treatment. The request for review should be made in writing within six months after notice of the decision.

If you are still dissatisfied after BCBSSC has reviewed the decision, you have 90 days in which to request, in writing, that the Employee Insurance Program (EIP) review the decision. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

COORDINATION OF BENEFITS

If you are covered by more than one dental plan, you may file a claim for reimbursement from both plans. Coordination of benefits is a system in which administrators of both plans will work together to see that you get the maximum benefit allowed. However, you will never receive more than 100 percent of your covered dental expenses.

For detailed information about coordination of benefits, including how to determine which plan pays first, see page 15. If your state dental coverage is secondary, you must send the explanation of benefits you receive from your primary plan with your claim to BCBSSC.

If you have additional questions, contact BCBSSC toll-free at 888-214-6230 or 803-264-7323 in the Columbia area, your benefits office or EIP.

For more information on what to do when your State Dental Plan coverage ends, please refer to the General Information Chapter on page 13 and 14.